Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: AR 2011 Senior Supplement Amendment Materials	SERFF Tr Num: UHLC-127202190	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 49018
Sub-TOI: H16G.002C Large Group Only - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Judith Davenport, Becky Kieran, Martha Blanke	Disposition Date: 06/23/2011
	Date Submitted: 06/08/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 01/01/2012		Implementation Date:

State Filing Description:

General Information

Project Name: AR 2011 Senior Supplement Amendment Materials	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 06/23/2011	
State Status Changed: 06/23/2011	Deemer Date:
Created By: Judith Davenport	Submitted By: Judith Davenport

Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related
PPACA Notes: null
Filing Description:

UnitedHealthcare Insurance Company (UnitedHealthcare), a member of the UnitedHealth Group family of companies, is submitting the enclosed large group health materials for your review and approval. These materials will be used with the large group policy forms, SRINS-POL, et al, that were previously Approved by your Department on February 20, 2009 in SERFF filing UHLC-126036498, State Tracking Number: 41573.

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49018*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*AR 2011 Senior Supplement Amendment Materials*		
Project Name/Number:	*AR 2011 Senior Supplement Amendment Materials/*		

This is a group health product that UnitedHealthcare offers to large employers in order to provide coverage for their eligible retirees and any eligible dependents, all of whom must be enrolled in Medicare Parts A and B. Although coverage is intended for individuals who are eligible retirees of an employer as well as the retiree's eligible dependents, all of whom must be enrolled in Medicare Parts A and B, this is not a standardized Medicare supplement policy. Unlike a Medicare supplement policy, this is a major medical policy that allows the Policyholder to customize their retiree plan by choosing various options (i.e. deductibles, copayments, plan maximums, etc.). It may also include benefits that are not covered by Medicare or that may be a state-mandated benefit that would not be covered by Medicare but that would be required in your state for any large group health plan.

The attached amendment, SRINS-AMEND-1, contains new text which has not previously been filed with your Department. In order to facilitate your review of this submission, complete provisions have been included in the Amendment, rather than just the changes. This Amendment is for the purpose of revising certain provisions that are in the previously approved Certificate booklet, SRINS-CERT-AR. The revised provisions will be included in any materials issued to new groups.

The Schedule of Benefits (SRINS-SOB-AR-1), and the Enrollment Form (SRINS-APP-NA-AR-1) have been completely rewritten as new documents. Therefore, they are being submitted as new forms rather than as revised forms. The Enrollment Form has been simplified so that it will be filled out by each person enrolling in the plan rather than including retiree and dependent information on the same form. The Schedule of Benefits has also been reformatted to include certain state-specific mandated benefits that may not be covered by Medicare. This new format will clarify how the plan will pay benefits when the plan is not paying secondary to Medicare.

The Vision and Neuromuscular Riders (SRINS-HR-AR-1, SRINS-VR-1, and SRINS-NMSR-1) have been revised only to add additional variability to the Schedule of Benefits portion of the Riders. The Hearing Aid Benefit Rider has been reformatted to more closely match the design other two Riders and clarifies that no Policy Deductible or Copayment applies to hearing aids.

Thank you very much for your consideration of this filing. Please don't hesitate to contact us if you have any questions.

Company and Contact

Filing Contact Information

Judith Davenport, Manager
5995 Plaza Dr.
Cypress, CA 90630

judy.davenport@uhc.com
714-226-3507 [Phone]
714-226-3238 [FAX]

Filing Company Information

UnitedHealthcare Insurance Company
185 Asylum Street

CoCode: 79413
Group Code: 707

State of Domicile: Connecticut
Company Type: Life and Health

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
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Hartford, CT 06103 Group Name: State ID Number:

(860) 702-5000 ext. [Phone] FEIN Number: 36-2739571

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00
Retaliatory?	No
Fee Explanation:	Six forms at $50.00 per form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	$300.00	06/08/2011	48480501

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/23/2011	06/23/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Hearing Aid Benefit Rider	Judith Davenport	06/08/2011	06/08/2011

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49018*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
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Disposition

Disposition Date: 06/23/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49018*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form *(revised)*	Hearing Aid Benefit Rider	Approved-Closed	Yes
Form	Vision Benefit Rider	Approved-Closed	Yes
Form	Neuromuscular Benefit Rider	Approved-Closed	Yes
Form	Hearing Aid Benefit Rider	Replaced	Yes

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49018*
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TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
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Amendment Letter

Submitted Date: 06/08/2011

Comments:

Just a correction for the Previous Filing Number and Replaced Form Number for the Hearing Aid Benefit Rider. The correct information has now been submitted.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
SRINS-HR-AR-1	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Hearing Aid Benefit Rider	Revised		42935	SRINS-HAOFFER-AR	45.300	SRINS-HR-AR-1.pdf

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49018*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*AR 2011 Senior Supplement Amendment Materials*		
Project Name/Number:	*AR 2011 Senior Supplement Amendment Materials/*		

Form Schedule

Lead Form Number: SRINS-AMEND-1

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/23/2011	SRINS-AMEND-1	Certificate Amendment, Insert Page, Endorsement or Rider	Amendment	Initial		52.400	SRINS-AMEND-1.pdf
Approved-Closed 06/23/2011	SRINS-APP-NA-AR-1	Application/Enrollment Form	Enrollment Form	Initial			SRINS-APP-NA-AR-1.pdf
Approved-Closed 06/23/2011	SRINS-SOB-AR-1	Schedule Pages	Schedule of Benefits	Initial			SRINS-SOB-AR-1.pdf
Approved-Closed 06/23/2011	SRINS-HR-AR-1	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Hearing Aid Benefit Rider	Revised	Replaced Form #: SRINS-HAOFFER-AR Previous Filing #: 42935	45.300	SRINS-HR-AR-1.pdf
Approved-Closed 06/23/2011	SRINS-VR-1	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Vision Benefit Rider	Revised	Replaced Form #: SRINS-VR Previous Filing #: 41573	45.100	SRINS-VR-1.pdf
Approved-	SRINS-	Policy/Cont	Neuromuscular	Revised	Replaced Form #:	43.600	SRINS-

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49018*
Company Tracking Number:			
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Closed NMSR-1 06/23/2011	ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Benefit Rider	SRINS-NMSR Previous Filing #: 41573	NMSR-1.pdf

UnitedHealthcare Insurance Company

Hartford, Connecticut

Amendment to:

Senior Supplement
Group Health Insurance Policy

[Policyholder: [John Doe]]
Effective Date: [month/date/year]

Your Senior Supplement group health insurance Policy, which includes the Policy, Certificate, Schedule of Benefits, and any applicable Riders, to which this Amendment is attached, is hereby amended as follows:

1. *The Foreign Country Travel Benefit (Medically Necessary Emergency Services) in the Inpatient and Outpatient Benefits sections of the Certificate is revised to read as follows*:

   Foreign Country Travel Benefit (Medically Necessary [Emergency] Services). Medically Necessary [Emergency] Hospital, Physician and medical care services received in a foreign country are covered if the Covered Person lost entitlement to Medicare solely because of a temporary absence from the United States. Benefits will be:

   - Limited to charges covered if care had been provided in the United States;
   - Limited to treatment that began during the Covered Person's first 60 days outside the United States. Proof of start of travel may be required;
   - Limited to Covered Persons whose primary residence is in the United States; and
   - Limited to those charges for which the Covered Person is required to pay.

   Note: Any charges for services incurred while in a foreign country are not covered unless specified in the Schedule of Benefits.

2. *The Hospice Services in the Outpatient Benefits section of the Certificate is removed. All Hospice Services will be covered under the Inpatient Benefits section of the Certificate*.

All other terms and conditions of the Policy remain as stated therein.

UnitedHealthcare Insurance Company

[Allen J. Sorbo]
President

Underwritten by
UnitedHealthcare Insurance Company

Enrollment Form

Please complete the entire form. Incomplete information can delay the enrollment process.
(Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

1. Personal Information

Applicant Last Name	Applicant First Name	MI	☐ Mr. ☐ Mrs. ☐ Ms.	Effective Date ___ / ___ / ___ mm dd yyyy
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow [☐ Domestic Partner]				Date of Birth ___ / ___ / ___ mm dd yyyy
Name of Retiree			Applicant's Relation to Retiree: ☐ Self ☐ Spouse ☐ Child [☐ Domestic Partner]	
Applicant's Medicare Claim #	Part A Effective Date ___ / ___ / ___ mm dd yyyy	Part B Effective Date ___ / ___ / ___ mm dd yyyy	Part D Effective Date ___ / ___ / ___ mm dd yyyy	
Are you currently on COBRA? ☐ Yes ☐ No If Yes, Qualifying Event		COBRA Qualifying Event Effective Date ___ / ___ / ___ mm dd yyyy		
Permanent Residence Street Address (P.O. Box is not allowed)	City		State	Zip
Mailing Address (only if different from your Permanent Residence Address)	City		State	Zip
Home Telephone Number ( )	Alternate Telephone Number ( )	[E-mail Address]		
[In the future, would you be willing to receive materials through electronic means? ☐ Yes ☐ No]				
I prefer to receive materials in the following language: ☐ Spanish ☐ Chinese (Spoken: ☐ Cantonese ☐ Mandarin) ☐ Other _____				

Last Name	First Name	Medicare Claim Number

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the following information. Providing this information will not affect your enrollment in the plan.			
Institution Name	Date of Admission ___ / ___ / ___ mm / dd / yyyy	Telephone Number ( )	
Address	City	State	Zip
Attending Physician's Name	Attending Physician's Telephone Number ( )		

2. Benefit Coordination / Other Insurance Carrier Information

1. Do you have other health insurance? ☐ Yes ☐ No
   If Yes, complete Section 1a. – 1d. below.

1a. Insurance Company Name	1b. Policy #	1c. Effective Date	1d. Other Employer Name and Address
		___ / ___ / ___ mm / dd / yyyy	
		___ / ___ / ___ mm / dd / yyyy	

2. Are you permanently disabled? ☐ Yes ☐ No If Yes, complete the following:

   2a. Date disability began: ___ / ___ / ___
mm / dd / yyyy

3. Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

4. Do you currently work or plan to work? ☐ Yes ☐ No

5. Are you currently a State Medicaid recipient? ☐ Yes ☐ No
   If yes, please provide your State Medicaid number:

FOR OFFICE USE ONLY

Retiree ☐ Yes ☐ No

Dependent ☐ Yes ☐ No

Group # _____

Plan Code _____

Verification: _____
Initial

Date _____ / _____ / _____

FOR EMPLOYER USE ONLY

☐ Enrollee is eligible for retiree coverage

Effective Date:

_____ / _____ / _____

_____
Initial

Last Name	First Name	Medicare Claim Number

3. Terms and Conditions

I am requesting enrollment under the UnitedHealthcare Insurance Company ("UnitedHealthcare") Group Policy offered through my former employer. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.
2. UnitedHealthcare or its designee shall have access and use of my medical records for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
3. Any material omission or intentional misrepesentation in answering the questions on the Enrollment Form may result in the denial of benefits and the termination of my coverage.
4. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).
5. All statements and descriptions in this Enrollment Form are deemed to be representations and not warranties.
6. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This is not a Medicare supplement plan. This is an employer group retiree plan and may provide coverages that are different from a Medicare supplement plan. If you have a Medicare supplement plan, you may not need both the Medicare supplement plan and the employer group retiree plan. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance.

I certify that I have read the Terms and Conditions printed on this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

Print Name of Applicant:		
Signature of Applicant or Authorized Representative:	Today's Date:	**Signature**

UNITEDHEALTHCARE INSURANCE COMPANY
[Hartford, Connecticut]

Schedule of Benefits
[Senior Supplement][UnitedHealthcare][Retiree Benefit][Plan]

[Group: ABC Company]
[Policy Number: XXXXXX]
[Original Effective Date of Policy: XXXXXX]

The Schedule of Benefits is a summary of any Deductibles, Coinsurance and other limits when You receive Covered Services and, with the Certificate, describes your coverage under the Policy. Please refer to Section One: Your Medical Benefits in Your Certificate for a more complete explanation of the specific services covered by the Policy. All Covered Services are subject to any Deductible, Coinsurance, [Out-of-Pocket Expense Maximum(s),] conditions, exclusions, limitations, terms and provisions of the Certificate, including any attachment or riders.

The benefits described in the Certificate are based on the assumption that Covered Persons are enrolled in Medicare Part A and Part B. For any Covered Expense that is a Medicare Eligible Expense, the amount payable by the company will be based upon that portion of the Covered Expenses that Medicare does not pay under Medicare Part A and Part B, subject to the conditions, exclusions, limitations, terms and provisions of the Certificate, including any attachments or riders. Covered Persons must use Medicare participating Providers, approved Facilities and approved Hospice agencies.

[DEDUCTIBLES, COINSURANCE MAXIMUMS]	PLAN PAYS	YOU PAY
[Calendar] [Plan] Year Deductible		
[Individual] [When a Covered Person reaches the Individual maximum Deductible for the [Calendar][Plan] Year, then the Deductible will be considered satisfied for the remainder of that [Calendar][Plan] Year.]	-0-	[None] [$100-$5,000] [Calendar] [Plan] [Year Deductible] [(with Deductible carried over when paid in the last [1-6] months of the year)]
[Family Maximum] [2 x Individual] [When Covered Expenses for family members accrue to the amount indicated, no additional [Calendar][Plan] Year Deductible will apply to the other family members for the rest of that [Calendar][Plan] Year.]	-0-	[None] [$200-$10,000] [Calendar] [Plan] [Year Deductible] [(with Deductible carried over when paid in the last [1-6] months of the year)]
[Coinsurance Maximum] [Out-of-Pocket Expense Maximum]		
[Individual] [When a Covered Person has satisfied the [Coinsurance Maximum][Out-of-Pocket Expense Maximum] for the [Calendar][Plan] Year, Covered Expenses will be paid at [100%] for the remainder of that [Calendar][Plan] Year.]	-0-	[None] [$250-$10,000]
[Family Maximum] [2 x Individual] [When Covered Persons have fully satisfied the [Coinsurance Maximum][Out-of-Pocket Expense Maximum] for the [Calendar][Plan] Year, Covered Expenses will be paid at [100%] for the remainder of that [Calendar][Plan] Year for all Covered Persons in your family.]	-0-	[$500-$20,000]

[Emergency and Urgent Care Services Copayment (per visit)	PLAN PAYS	YOU PAY
Emergency Services After satisfaction of the Copayment, benefits will be paid the same as for All Other Inpatient Benefits.	-0- Copayments are the responsibility of the Covered Person	[[$0-$200] Copayment per visit] [(Not] [[(]waived if admitted)]
Urgent Care Services After satisfaction of the Copayment, benefits will be paid the same as for All Other Outpatient Benefits		[[$0-$200] Copayment per visit] [(Not] [[(]waived if admitted)]]
INPATIENT BENEFITS	PLAN PAYS	YOU PAY
Medicare Part A Deductible Days 1-60 of Inpatient Hospital Services	[0%-100%] [[$0-$XXXX]] of Part A Deductible]	[0%-100%] [[$0-$XXXX]] of Part A Deductible]
Inpatient Hospital Services		
[Days 61-90]	[[50%-100%]Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$2,000] Copayment] [per [admission][day]] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
[Days 91-150 (While using 60 lifetime reserve days)]	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$2,000] Copayment] [per [admission][day]] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
[Days 151-365 - lifetime additional reserve days]	[[50%-100%] Coinsurance] [after Copayment] [Not Covered]	[[0%-50%] Coinsurance] [[$0-$2,000] Copayment] [per [admission][day]] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
[Beyond 365 lifetime additional reserve days] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits per admission.]	[[50%-100%] Coinsurance] [after Copayment] [Not Covered]	[[0%-50%] Coinsurance] [[$0-$2,000] Copayment] [per [admission][day]] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]

INPATIENT BENEFITS	PLAN PAYS	YOU PAY
Inpatient Mental Health [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits per admission.]	Same as Inpatient Hospital above	[[0%-50%] Coinsurance] [[$0-$2,000] Copayment] [per [admission][day]] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Skilled Nursing Facility (SNF) [Days 1-20] Covered by Medicare]	[Not Covered] -0-	[Balance] -0-
[Days 21-100]	[[50%-100%] Coinsurance] [after Copayment] [up to [$0-$2,000] per day maximum] [Not Covered]	[[$0-$2,000] Copayment] [Balance] [remaining after the per day maximum has been paid by the Plan] [$0]
[Days 101-365]	[[50%-100%] Coinsurance] [after Copayment] [up to [$0-$2,000] per day maximum] [Not Covered]	[[$0-$2,000] Copayment] [Balance] [remaining after the per day maximum has been paid by the Plan] [$0]
[Beyond 365 Days] [SNF - prior hospital stay requirement [is][is not] waived] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits per admission.]	[[50%-100%] Coinsurance] [after Copayment] [up to [$0-$2,000] per day maximum] [Not Covered]	[[$0-$2,000] Copayment] [Balance] [remaining after the per day maximum has been paid by the Plan] [$0]

INPATIENT BENEFITS	PLAN PAYS	YOU PAY
Blood and Blood Products Blood (First three pints [are][are not] covered)	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$500] Copayment] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Hospice Services Respite Care	[[50%-100%] Coinsurance] [[50%-100%] Coinsurance]	[Balance] [$0] [Balance] [$0]
Inpatient Physician Services (including specialists and other licensed health care professionals)	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$500] Copayment] [per visit] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
[Private Duty Nursing Services]	[[50%-100%] Coinsurance] [after Copayment] [up to a maximum of] [$50-$5,000] [per day [10-100 visits per [Calendar][Plan] Year]	[[0%-50%] Coinsurance] [[$0-$500] Copayment] [per visit] [[0%-50%] Coinsurance after Copayment] [Balance] [remaining after the [Calendar][Plan] Year maximum has been paid by the Plan] [$0]
All Other Inpatient Services Billed by Hospital or Facility	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$2,000] Copayment] [per [admission][day]] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]

OUTPATIENT & PART B BENEFITS	PLAN PAYS	YOU PAY
Medicare Part B Deductible	[0%-100%] [[$0-$XXX]] of Part B Deductible]	[0%-100%] [[$0-$XXX]] of Part B Deductible]
[Medicare Part B Excess Charges][*]	[[0%-100%] Coinsurance]	[[0%-100%] Coinsurance]
Ambulance	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$200] Copayment] [[0%-50%] Coinsurance after Copayment]
Outpatient Physician Services (Office Visits)	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$200] Copayment] [per office visit] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Outpatient Physician Services for Specialists (Office Visits)	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$200] Copayment] [per office visit] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Outpatient Physician Services (Outpatient Surgery) (including specialists and other licensed health care professionals)	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$500] Copayment] [per procedure] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Outpatient Surgery (Facilities)	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$2,000] Copayment] [per procedure] [[0%-50%] Coinsurance after Copayment] [Balance][$0]

*[*Does not apply to the Out-of-Pocket Expense Maximum]*

OUTPATIENT & PART B BENEFITS	PLAN PAYS	YOU PAY
Blood and Blood Products Blood (First three pints [are][are not] covered)	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$500] Copayment] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
[Infusion Therapy] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits.]	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$200] Copayment] [per visit] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Periodic Health Screenings (Preventive Care) - Please Refer to Your Certificate	100% Coinsurance	$0
Outpatient Mental Health Care	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$200] Copayment] [per visit] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Alcohol, Drug or other Substance Abuse	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$200] Copayment] [per visit] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
[[Outpatient Injectables (Medicare Part B Drugs Only) [Home Health] [Office-Based] [Self Administered]] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits.]	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$2,000] Copayment] [per visit] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]

OUTPATIENT & PART B BENEFITS	PLAN PAYS	YOU PAY
[Outpatient Prescription Drugs Covered by Medicare (Medicare Part B Drugs Only) [Oral Chemo] [Anti-Emetics] [Antigens]]	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$200] Copayment] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Durable Medical Equipment [(when covered by Medicare)] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits.]	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$200] Copayment] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Hearing Exams (for obtaining hearing aids)	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$200] Copayment] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
Home Health Care (for expenses covered by Medicare)	100% Coinsurance	$0
[Private Duty Nursing Services]	[[50%-100%] Coinsurance] [after Copayment] [up to a maximum of] [$50-$5,000] [per day] [10-100 visits per [Calendar] [Plan] Year]	[[0%-50%] Coinsurance] [[$0-$500] Copayment] [per visit] [[0%-50%] Coinsurance after Copayment] [Balance][$0]
All Other Outpatient Benefits	[[50%-100%] Coinsurance] [after Copayment]	[[0%-50%] Coinsurance] [[$0-$2,000] Copayment] [[0%-50%] Coinsurance after Copayment] [Balance] [$0]
ADDITIONAL BENEFITS	PLAN PAYS	YOU PAY
[Foreign Travel Benefit]	[Covered in Full] [[$0-$500] Deductible] [per] [Calendar] [Plan] Year] [[50%-100%] Coinsurance] [up	[$0-$500] Deductible] [per [Calendar] [Plan] Year]

	to a maximum benefit of [$100-$300,000] per [Calendar] [Plan] [Year] [lifetime]	[Balance] [$0]
[Home Health Care Not Covered by Medicare] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits.]	[[50%-100%] Coinsurance] [after Copayment] [up to a maximum benefit of [$100-$15,000] per [Calendar] [Plan] Year] [up to a maximum of [10-100] visits per [Calendar] [Plan] Year]]	[[$0-$200] Copayment per visit] [Balance] [$0]
[Periodic Health Screenings (Preventive Care) Not Covered by Medicare]	[[50%-100%] Coinsurance] [after Copayment] [up to a maximum benefit of [$0-$1,000]] [per [Calendar][Plan] Year]	[[$0-$100] Copayment per visit] [Balance] [$0]

THIS POLICY HAS CERTAIN BENEFIT MAXIMUMS. PLEASE REVIEW THIS INFORMATION CAREFULLY SO YOU WILL UNDERSTAND YOUR BENEFITS UNDER THIS PLAN.

NOTE: For Covered Services which are not Medicare Eligible Expenses, Covered Expenses will be paid in accordance with the Usual and Customary Charge criteria as defined in the Certificate.

[Preauthorization is required prior to obtaining certain benefits. [Failure to Preauthorize services will result in a reduction in the benefits payable for Covered Expenses under the Policy.] The Company will conduct a retroactive review to determine the Medical Necessity of the service, and services deemed not Medically Necessary will not be eligible for benefits under the Policy. Additional out-of-pocket expenses incurred by You for not Preauthorizing services will not apply toward Your [Calendar][Plan] Year Deductible or Coinsurance Maximum. To avoid any penalty, please refer to "Preauthorization Requirements."]

[Deductible Carry-Over. Covered Expense applied to a Covered Person's [Calendar][Plan] Year Deductible during the last [one-six (1-6)] months of a [Calendar][Plan] Year will apply to that Covered Person's [Calendar][Plan] Year Deductible for the following [Calendar][Plan] Year.]

[Deductible Takeover. If the Policy is replacing a similar Policy that had been issued to the Group Policyholder, any portion of any Deductible the Covered Person had satisfied under the replaced plan shall apply to the satisfaction of the Covered Person's initial [Calendar][Plan] Year Deductible under the Policy. Proof of Deductible satisfaction under the replaced plan will be required upon submission of the initial Claim for benefits to be payable under the Policy.]

UNITEDHEALTHCARE INSURANCE COMPANY
(the "Company")
[Hartford, Connecticut]

[SENIOR SUPPLEMENT]
[UNITEDHEALTHCARE] [RETIREE BENEFIT] [PLAN]
Hearing Aid Benefit Rider
(For Benefits Not Covered by Medicare)

UnitedHealthcare Insurance Company
(Herein called We, Our, Us and the Company)

This Rider is issued as part of the Policy and any Certificate to which it is attached. This Rider is subject to all the terms and provisions of the Policy, except as stated below. In consideration of any additional premium, We will provide the coverage described in this Rider.

BENEFITS

The Company will pay a Hearing Aid Benefit for Covered Expenses incurred by a Covered Person for Covered Services described below in the Hearing Aid Schedule of Benefits, subject to the Exclusions and Limitations described in this Rider, which do not exceed any applicable maximum shown in the Certificate.

This benefit is not subject to any Deductibles or Copayments shown in the Policy.

Hearing Aid Schedule of Benefits. Benefits will not exceed the limits set forth below:

Hearing Aid Schedule of Benefits	
Hearing Aids	Limited to 1 Hearing Aid per ear every 3 [Calendar][Plan} Years.
Hearing Aid Maximum Benefit: [[$1,400-$5,000] per ear for each 3-year period.	

COVERED SERVICES

Covered Services are limited to those services that are:

1. for the care of a Hearing Impairment or loss; and
2. provided by a Physician or person licensed by the state to dispense a hearing aid or hearing instrument.

HEARING AID BENEFIT MAXIMUM

The Hearing Aid Benefit Maximum per Covered Person for all Covered Expenses is the amount shown above in the Hearing Aid Benefit Schedule of Benefits. It applies separately to each Covered Person.

DEFINITIONS

[Calendar Year means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.]

Hearing Aid means an instrument or device, including repair and replacement parts that: (a) is designed and offered for the purpose of aiding persons with or compensating for impaired hearing; (b) is worn in or on the body; and (c) is generally not useful to a person in the absence of a hearing impairment.

Hearing Impairment means a reduction in the ability to perceive sound and may range from slight to complete deafness.

[Plan Year means any consecutive 12 month period beginning on the Effective Date shown in the Policy.]

EXCLUSIONS AND LIMITATIONS

Unless provided for in this Rider, Hearing Aid Benefits are not payable for expenses excluded by the Certificate or for the following expenses:

1. Care or treatment for a Hearing Impairment due to a functional nervous disorder;
2. Services or supplies covered in whole or in part under any other portion of the Policy or under any other medical expense benefits for hearing benefits provided by the Employer;
3. Medical or surgical treatment of Hearing Impairment;
4. Outpatient Prescription Drugs, or other medications to treat Hearing Impairment;
5. Any treatment or services caused by or arising out of the course of employment, or covered under any public liability insurance, including but not limited to Workers' Compensation programs;
6. Hearing Aids prescribed by a Physician prior to the Covered Person's Effective Date under the Policy, or after the Covered Person's termination of coverage under the Policy;
7. Hearing Aids prescribed by a Physician while the Covered Person is covered under the Policy, but delivered to the Covered Person more than thirty (30) days after the Covered Person's termination of coverage under the Policy;]
8. Hearing Aids for which the Covered Person is not obligated to pay, or for which no charge would be made in the absence of Hearing Aid coverage under the Policy;
9. Hearing Aids which are not Medically Necessary or not prescribed by a Physician;
10. Hearing Aids that do not meet professionally accepted standards or practice, including Hearing Aids which are for Experimental and/or Investigational treatment;
11. Hearing Aids provided by any governmental agency or that are obtained by the Covered Person without cost;
12. Replacement of Hearing Aids that are lost, broken or stolen unless, at the time of such replacement, the Covered Person is otherwise eligible for a hearing aid benefit under the Policy;
13. Charges for the completion of any benefit request forms.

Payment of Hearing Aid Benefits is subject to all of the terms of the Policy that are not inconsistent with these provisions, including, but not limited to, the Policy Exclusions and Limitations.

EFFECTIVE DATE

This Rider is effective on the Effective Date of the Group Health Insurance Policy and Certificate to which it is attached, and is subject to all the provisions, definitions, limitations and conditions of the Policy and Certificate. This Rider terminates at the same time as the Group Health Insurance Policy and Certificate. This Rider does not change, waive or extend any part of the Policy and Certificate other than as stated herein.

Signed on behalf of UnitedHealthcare Insurance Company

[Allen J. Sorbo], President

NOTES

Questions?

[1-800-851-3802][, TTY 711]
[(or for the hearing impaired, 1-800-647-6038)]
[8 a.m. to 8 p.m.] [local time]
[7 days a week] [Monday through Friday]

[Visit our Web site at *www.XXXXXXXX@uhc.com*]

UNITEDHEALTHCARE INSURANCE COMPANY
(the "Company")
[Hartford, Connecticut]

[SENIOR SUPPLEMENT]
[UNITEDHEALTHCARE] [RETIREE BENEFIT] [PLAN]
Vision Care Benefit Rider
(For Benefits Not Covered by Medicare)

UnitedHealthcare Insurance Company
(Herein called We, Our, Us and the Company)

This Rider is issued as part of the Policy and any Certificate to which it is attached. This Rider is subject to all the terms and provisions of the Policy, except as stated below. In consideration of any additional premium, We will provide the coverage described in this Rider.

BENEFITS

The Company will pay a Vision Care Benefit for Covered Expenses incurred by a Covered Person for Covered Services described below in the Vision Care Schedule of Benefits, subject to the Exclusions and Limitations described in this Rider, which do not exceed any applicable maximum shown in the Certificate.

Vision Care Schedule of Benefits. Benefits will not exceed the limits set forth below:

Vision Care Schedule of Benefits	
[Eye Examination for eyeglasses or contact lenses (refraction): Benefits limited to [1-2] eye examination[s] [per] [every] [Plan Year] [Calendar Year] [[12-48] month period]]	[Copayment][Coinsurance]: [50%–100%] [$0–$100] [per visit]
[Lenses and frames or contact lenses: [Unlimited] [Benefits limited to [1-2] pair of lenses and frames or [1-2] pair of contact lenses [but not both] per [Plan Year] [Calendar Year] [[12-48] month period]	See Eyewear Maximum Benefit below.
[Eye Examination Maximum Benefit: [[$50-$500] [per][every] [[12-48] month period] [Plan Year] [Calendar Year]] [[$25–$100] per visit]]	
[Eyewear Maximum Benefit: [[$50–$5,000] [per][every] [[12-48] month period] [Plan Year] [Calendar Year]]	

COVERED SERVICES

Covered Services are limited to those Vision Care services which are provided by a Physician, an Optometrist or Optician for [an eye examination] [and] [Eyewear] to the Covered Person.

VISION CARE BENEFIT MAXIMUM

The Vision Care Benefit Maximum per Covered Person for all Covered Expenses is the amount shown above in the Vision Care Benefit Schedule of Benefits. It applies separately to each Covered Person.

DEFINITIONS

[Calendar Year means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.]

[Eyewear means frames, single vision, bifocal, trifocal, and lenticular lenses and contact lenses.]

[Plan Year means any consecutive 12 month period beginning on the Effective Date shown in the Policy.]

[Vision Care means those services prescribed by a Physician, an Optometrist or Optician for the care and treatment of the Covered Person's vision.]

EXCLUSIONS AND LIMITATIONS

Unless provided for in this Rider, Vision Care Benefits are not payable for expenses excluded by the Certificate or for the following expenses:

1. Medical or surgical treatment of the eye;
2. Outpatient Prescription Drugs or other medications for the eyes;
3. Experimental and/or Investigational treatment;
4. Care or treatment for any Sickness or Injury arising out of or in the course of employment, or for which benefits are payable under any Workers' compensation Act or similar legislation, or services provided by a government agency;
5. Charges for completion of insurance or other claim forms, or charges for missed or rescheduled appointments;
6. [Eye examinations;]
7. [Lenses which do not require a prescription written by a Physician, including eyeglasses or lenses which provide no visual correction or are for cosmetic use;]
8. [All lenses, frames, eyeglasses, contact lenses whether or not they require a prescription;]
9. [Duplicate eyeglass lenses or frames;]
10. [Two (2) pairs of eyeglasses in lieu of bifocals; three (3) pairs of eyeglasses in lieu of trifocals].

EFFECTIVE DATE

This Rider is effective on the Effective Date of the Group Health Insurance Policy and Certificate to which it is attached, and is subject to all the provisions, definitions, limitations and conditions of the Policy and Certificate. This Rider terminates at the same time as the Group Health Insurance Policy and Certificate. This Rider does not change, waive or extend any part of the Policy and Certificate other than as stated herein.

Signed on behalf of UnitedHealthcare Insurance Company

[Allen J. Sorbo], President

NOTES

Underwritten by UnitedHealthcare Insurance Company

Questions?

[1-800-851-3802][, TTY 711]
[(or for the hearing impaired, 1-800-647-6038)]
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UNITEDHEALTHCARE INSURANCE COMPANY
(the "Company")
[Hartford, Connecticut]

[SENIOR SUPPLEMENT]
[UNITEDHEALTHCARE] [RETIREE BENEFIT] [PLAN]

Neuromuscular Skeletal Disorders Benefit Rider
(For Benefits Not Covered by Medicare)

UnitedHealthcare Insurance Company
(Herein called We, Our, Us and the Company)

This Rider is issued as part of the Policy and any Certificate to which it is attached. This Rider is subject to all the terms and provisions of the Policy, except as stated below. In consideration of any additional premium, We will provide the coverage described in this Rider.

BENEFITS

Covered Services will include the treatment of Neuromuscular Skeletal Disorders. Treatment may include, but is not limited to: the therapeutic use of heat; cold; exercise; electricity; ultraviolet radiation; manipulation of the spine or massage for the purpose of improving circulation; strengthening muscles; or encouraging the return of motion.

Neuromuscular Skeletal Disorders Schedule of Benefits. Benefits will not exceed the limits set forth below:

Neuromuscular Skeletal Disorders Benefit	
Office Visits: Limited to [[12–30] visits per [Plan Year][Calendar Year]	[Copayment][Coinsurance]: [50%–100%] [$0–$100] [per visit]
Maximum Benefit: [[$25–$100] per visit]] [[$500–$5,000] per [Plan Year][Calendar Year]]	

COVERED SERVICES

The treatment will be considered Covered Services only if:
1. the treatment is performed by an individual who is licensed or registered to perform such therapy; and
2. any medical appliance or equipment that is required for the treatment has been prescribed by a Physician.

NEUROMUSCULAR SKELETAL DISORDERS BENEFIT MAXIMUM

The Neuromuscular Skeletal Disorders Benefit Maximum per Covered Person for all Covered Expenses is the amount shown above in the Neuromuscular Skeletal Disorders Schedule of Benefits. It applies separately to each Covered Person.

DEFINITIONS

[Calendar Year means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.]

[Neuromuscular Skeletal Disorders means misalignment of skeletal structures and muscular weaknesses, imbalance, and disorders related to the spinal cord, neck and joints.]

[Plan Year means any consecutive 12 month period beginning on the Effective Date shown in the Policy.]

EXCLUSIONS AND LIMITATIONS

Unless provided for in this Rider, benefits for treatment of Neuromuscular Skeletal Disorders are not payable for expenses excluded by the Certificate or for, or in connection with, the following treatments, services or supplies:

1. Services for examination and/or treatment of strictly non-Neuromuscular-Skeletal Disorders;
2. Services or treatments not documented as clinically necessary and appropriate or classified as Experimental or Investigational;
3. Diagnostic Scanning, including Magnetic Resonance Imaging (MRI), CAT Scans, and/or other types of diagnostic scanning such as Thermography;
4. Treatment of services for pre-employment physicals or vocational rehabilitation;
5. Any treatment or services caused by or arising out of the course of employment, or covered under any public liability insurance, including but not limited to Workers' Compensation programs;
6. Hypnotherapy, behavior training, sleep therapy and weight programs, educational programs, non-medical self-care or self-help physical exercise training or any related diagnostic testing;
7. Vitamins, minerals, nutritional supplements or other similar-type products;
8. Manipulation under Anesthesia, Hospitalization or any related services;
9. Air conditioners, air purifiers, therapeutic mattress supplies or any other similar device or appliance; and
10. X-rays taken to demonstrate misalignment.

Effective Date

This Rider is effective on the Effective Date of the Group Health Insurance Policy and Certificate to which it is attached, and is subject to all the provisions, definitions, limitations and conditions of the Policy and Certificate. This Rider terminates at the same time as the Group Health Insurance Policy and Certificate. This Rider does not change, waive or extend any part of the Policy and Certificate other than as stated herein.

Signed on behalf of UnitedHealthcare Insurance Company

[Allen J. Sorbo], President

NOTES

Underwritten by UnitedHealthcare Insurance Company

Questions?

[1-800-851-3802][, TTY 711]
[(or for the hearing impaired, 1-800-647-6038)]
[8 a.m. to 8 p.m.] [local time]
[7 days a week] [Monday through Friday]

[Visit our Web site at *www.XXXXXXXX@uhc.com*]

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49018*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*AR 2011 Senior Supplement Amendment Materials*		
Project Name/Number:	*AR 2011 Senior Supplement Amendment Materials/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	06/23/2011

Comments:
Attached is the Flesch Certification of Readability for these documents.

Attachment:
CERTIFICATION OF READABILITY.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	06/23/2011

Comments:
The new Enrollment Form (SRINS-APP-NA-AR-1) is attached to the Forms tab.

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	06/23/2011

Bypass Reason: Although this product is filed as medical plan, it only provides coverage to retirees who are already covered under Medicare Part A and Part B as their primary health coverage. It does not provide any coverage for an employer group's active employees. Is it also not an HMO or PPO product. Since we always pay secondary to Medicare for this product, we do not apply any annual or lifetime limits to any of the coverages, including essential benefits. This product does not include any of the restrictions that PPACA is intended to remove. We also do not limit any coverage for eligible dependents as long as they meet the eligibility requirements of being enrolled in Medicare Part A and Part B. Therefore, as a plan that is only being provided to Medicare eligible retirees, this policy would not be subject to the PPACA requirements.

Comments:

CERTIFICATION OF READABILITY

Re: UnitedHealthcare Insurance Company
NAIC: #79413, FEIN 35-2739571

I certify that the forms in this filing have been tested under the Flesch methodology and meet the minimum required reading ease score. The combination of forms has a score of 45.

The following language or terminology has been excepted from scoring: Name and address of Insurer; Name, number and title of the form; Titles, Captions and Sub-captions; schedules or tables; words defined in the policy; and any language required by any federal or state law, regulation or agency interpretation.

Signature of Authorized Representative

Assistant Secretary
Title of Authorized Representative

Paul D. Kallmeyer
Printed Name of Authorized Representative

June 8, 2011
Date

SERFF Tracking Number:	*UHLC-127202190*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49018*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*AR 2011 Senior Supplement Amendment Materials*		
Project Name/Number:	*AR 2011 Senior Supplement Amendment Materials/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/08/2011	Form	Hearing Aid Benefit Rider	06/08/2011	SRINS-HR-AR-1.pdf